

# IPAS & PASRR MANUAL

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## Chapter 7

### MEDICAID WAIVER AND CASE MANAGEMENT

#### 7.1 MEDICAID WAIVER SERVICES

The Medicaid Waiver Services program applies to IPAS in that:

- a) applicants for Indiana's "Aged and Disabled" (A&D) and "Medically Fragile Children" (MFC) Waivers must participate in Indiana's IPAS program; and
- b) eligibility for Medicaid Waiver services should be considered by the IPAS assessor when constructing the IPAS and/or PASRR plan of care.

Medicaid Waiver Services are those specific in-home and community-based services available for Medicaid reimbursement only under a federally approved "waiver." The parameters of each Medicaid Waiver service are contingent on the limits requested by each state and approved by HCFA. IPAS requirements must be met by individuals covered under these two (2) Waivers.

##### 7.1.1 General Information

The A&D and MFC Waivers provide services to aged adults and persons with disabilities who would otherwise require the level of services provided in a NF.

###### 7.1.1.1 Eligibility

In general, Medicaid A&D and MFC Waiver eligibility requirements direct that the individual must be:

- (a) eligible for Medicaid;
- (b) at risk of institutionalization (in the absence of Medicaid Waiver services);
- (c) screened under IPAS;
- (d) meet need for NF level of services criteria (Level of Care); and
- (e) be given the choice to utilize the Medicaid Waiver services or be admitted to a NF.

The criterion of "at risk of institutionalization" means that:

- a) the individual must, but for the availability of Medicaid Waiver service(s), meet all requirements of need for NF level of services; and
- b) if qualified, must be given a choice to accept the Medicaid Waiver service(s); or
- c) be admitted to a NF.

All requirements for NF placement must be met and approval for NF admission rendered PRIOR to the offer of Medicaid Waiver services.

Each Medicaid Waiver, depending on the type of Waiver being considered, may impose other restrictions.

###### 7.1.1.2 PASRR Requirements

As soon as a recipient of A&D or MFC Medicaid Waiver services chooses placement in a NF, the IPAS Agency will:

- a) determine whether PASRR Level II assessment is required; and
- b) if Level II is needed, make referrals for Level II directly to the CMHC or D&E Team;
- c) send the letter of Level II referral to the applicant and/or health representative, Waiver Services case manager, and NF; and
- d) regardless of need for Level II, send a copy of the IPAS agency certified Level I to the NF.

See Chapter 15 for instructions for processing Level II assessments for Medicaid Waiver recipients.

##### 7.1.2 NF Admission of a Medicaid Waiver Services Recipient

The "freedom of choice" to enter a NF is applicable:

- a) throughout the time that an individual meets the Waiver requirements; and
- b) is an active recipient of the A&D and MFC Waivers.

#### 7.1.2.1 NF Action

When a NF receives a request for admission from a Medicaid Waiver recipient, the NF must:

- a) immediately notify the IPAS agency and/or the Waiver Case Manager of the request;
- b) PRIOR to admission or immediately following designee approved admission.

As always, the NF must NOT admit or retain any individual:

- a) for whom it cannot provide the level of services needed; or
- b) who requires PASRR Level II, but has not been assessed and approved for placement.

A NF must assure that, for every individual it admits, it has a copy on the chart of the:

- a) PAS Form 4B; or
- b) for Medicaid Waiver recipients, the HCBS Form 3: Statement for Freedom of Choice (Appendix S) or the HCBS Form 7: Transmittal for Medicaid Level of Care Eligibility (Appendix R).

#### 7.1.2.2 Medicaid Waiver Recipient/Care Manager Action

A Medicaid Waiver recipient must:

- a) report any change in circumstances which affects eligibility for Waiver services; and
- b) choosing NF placement is a reportable change.

The individual or the individual's legal representative must immediately contact the Medicaid Waiver care manager.

It is the responsibility of the Medicaid Case Manager to:

- a) assure that the recipient understands the need to report such changes PRIOR to NF admission, whenever possible or immediately following NF admission; and
- b) report or assure that the selection of NF admission is reported to the appropriate IPAS agency for a determination of need for Level II assessment.

#### 7.1.2.3 Transmittal of Case Record to NF

Each NF is required to:

- a) maintain certain case documentation on file; and
- b) utilize the assessment and needs findings in its care planning.

The Waiver Care Manager must provide the NF with the necessary IPAS/PASRR documentation and case record at the time of admission.

Applicable documentation which the Waiver Case Manager must provide and which the NF must maintain on the NF active record and use for the Care Plan corresponds to the IPAS case packet. It includes, at a minimum, the following forms:

- a) Application for Long-Term Care Services;
- b) PASRR Level I;
- c) Form 450B, Sections I-III, Physician Certification of Need for Long-Term Care Services;
- d) (For MR/DD, include Form 450B, Section VI);
- e) PASRR Level II Assessment, when applicable;
- f) Long-Term Care Services Eligibility Screen;
- g) Form HCBS 3, Waiver Freedom of Choice, showing choice of NF or HCBS Form 7, Transmittal for Medicaid Level of Care Eligibility.

#### 7.1.3 NF Request for Medicaid Reimbursement

A NF submits its request for Medicaid reimbursement of NF per diem to OMPP following the usual procedures.

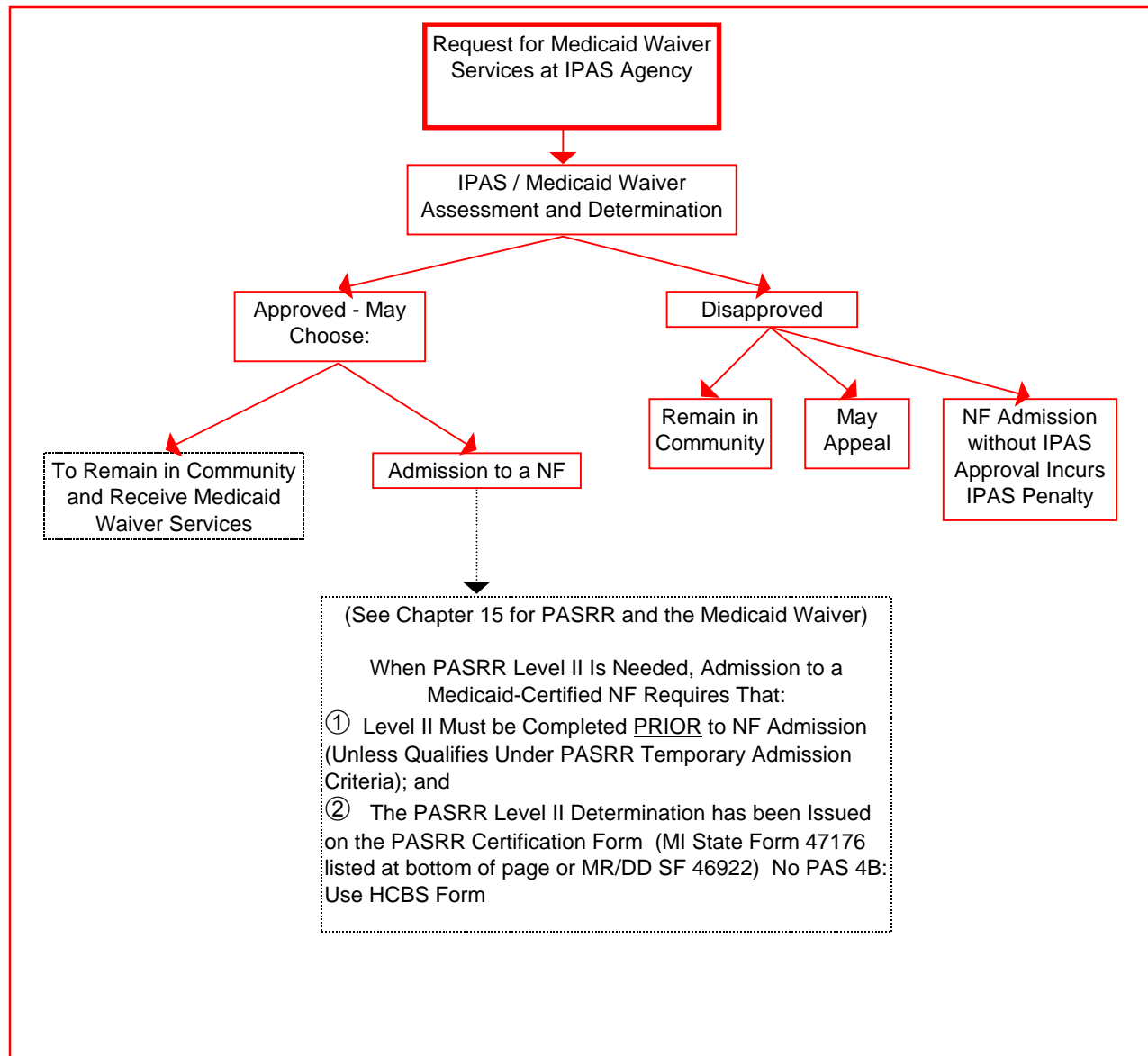
There will not be a PAS Form 4B for an individual who, immediately prior to NF admission, was a Waiver Services recipient. Either the Form HCBS 3 or HCBS 7 will replace the PAS 4B when the NF requests reimbursement for NF per diem from OMPP.

To assure that OMPP can expeditiously process the request for NF per diem approval, documentation submitted to OMPP needs:

- a) to be clearly marked by the NF as "Medicaid Waiver Services;"
  - b) in the top margin of the Form 450B;
- to alert OMPP to the status of the request.

## IPAS AND THE MEDICAID WAIVER PROCESS

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## 7.2 CASE MANAGEMENT REFERRAL

For all denied cases, the IPAS assessor or coordinator must:

- a) make a bona fide referral of the individual to available case management service(s);
- b) provide information on the assessment and necessary service needs identified through the IPAS assessment and care-planning.

This information will avoid duplication of effort and expedite processing by the case management system receiving the referral.

When no case management service is available or the individual does not meet requirements, the IPAS coordinator should assure that the applicant or his/her representative receives all service information which

may have resulted from the IPAS assessment and care plan. This information should be detailed enough that the individual or interested representative will be able to pursue identified services or options.

